AMENDED IN SENATE JUNE 14, 2000

AMENDED IN SENATE MAY 30, 2000

CALIFORNIA LEGISLATURE—1999–2000 REGULAR SESSION

ASSEMBLY BILL No. 2616

Introduced by Assembly Member Margett

February 25, 2000

An act to amend ~~Section~~ *Sections 785 and* 10123.13 of the Insurance Code, relating to health insurance.

LEGISLATIVE COUNSEL'S DIGEST

AB 2616, as amended, Margett. Health insurance: payment of claims.

Existing law regulates providers and certain insurers that cover hospital, medical, and surgical expenses with respect to the reimbursement by insurers of claims of providers. These provisions, among other matters, specify that a claim is reasonably contested if the insurer has not received a completed claim and all information necessary to determine payer liability for the claim or has not been granted reasonable access to information concerning provider services.

This bill would prohibit these insurers from requesting information that is not reasonably necessary to determine liability for the payment of a claim and would require them to pay providers the cost, as specified, of duplicating all information they request in connection with a contested claim.

Existing law regulates the provision of insurance to senior citizens and exempts various classes of insurance from the laws regulating insurance for senior citizens, including, until January 1, 2001, disability policies or certificates that are sold through direct response methods of delivery.

This bill would extend the duration of that exemption to January 1, 2002.

Vote: majority. Appropriation: no. Fiscal committee: no. State-mandated local program: no.

The people of the State of California do enact as follows:

SECTION 1. *Section 785 of the Insurance Code is amended to read:*

785. (a) All insurers, brokers, agents, and others engaged in the transaction of insurance owe a prospective insured who is age 65 years or older, a duty of honesty, good faith, and fair dealing. This duty is in addition to any other duty, whether express or implied, that may exist.

(b) Conduct of an insurer, broker, or agent, or other person engaged in the transaction of insurance, during the offer and sale of a policy or certificate previous to the purchase is relevant to any action alleging a breach of the duty of good faith and fair dealing.

(c) Except where explicitly provided to the contrary, this article shall not apply to any of the following:

(1) Medicare supplement insurance as defined in subdivision (b) of Section 10192.1.

(2) Long-term care insurance as defined in Section 10231.2.

(3) Disability coverage provided through the insured's employer or former employer.

(4) Disability insurance policies or certificates principally designed to provide coverage for accidents or expenses incurred while traveling if the premium for the policy or certificate is ten dollars ($10) or less.

(5) Blanket disability insurance as defined in Section 10270.3.

(6) Credit disability insurance as defined in Section 779.2.

(7) Accidental death insurance.

(8) Until January 1, ~~2001~~ *2002*, disability policies or certificates that are sold through direct response methods of delivery.

(9) Disability income insurance as defined in subdivision (i) of Section 799.01.

(d) Provided that the requirements of Section 10296 are met, this article shall not apply to transportation ticket policies and baggage insurance policy types allowable for sale by travel agents pursuant to Section 1753.

SEC. 2. Section 10123.13 of the Insurance Code is amended to read:

10123.13. (a) Every insurer issuing group or individual policies of disability insurance that covers hospital, medical, or surgical expenses, including those telemedicine services covered by the insurer as defined in subdivision (a) of Section 2290.5 of the Business and Professions Code, shall reimburse claims or any portion of any claim, whether in state or out of state, for those expenses as soon as practical, but no later than 30 working days after receipt of the claim by the insurer unless the claim or portion thereof is contested by the insurer, in which case the claimant shall be notified, in writing, that the claim is contested or denied, within 30 working days after receipt of the claim by the insurer. The notice that a claim is being contested shall identify the portion of the claim that is contested and the specific reasons for contesting the claim.

(b) If an uncontested claim is not reimbursed by delivery to the claimant's address of record within 30 working days after receipt, interest shall accrue at the rate of 10 percent per annum beginning with the first calendar day after the 30-working day period.

(c) For purposes of this section, a claim, or portion thereof, is reasonably contested when the insurer has not received a completed claim and all information necessary to determine payer liability for the claim, or has not been

granted reasonable access to information concerning provider services. Information necessary to determine liability for the claims includes, but is not limited to, reports of investigations concerning fraud and misrepresentation, and necessary consents, releases, and assignments, a claim on appeal, or other information necessary for the insurer to determine the medical necessity for the health care services provided to the claimant. An insurer shall pay a provider for duplicating all information it requests in connection with a contested claim, and for patient records, as follows:

(1) Except as provided in paragraph (2), the insurer shall pay the provider for copying twenty-five cents ($0.25) per page, or fifty cents ($0.50) per page for records that are copied from microfilm.

(2) The insurer shall pay the provider all reasonable costs, not exceeding actual costs, incurred by the provider in providing the insurer copies of X-rays, or tracings derived from electrocardiography, electroencephalography, or electromyography.

(d) No insurer subject to this section shall request information that is not reasonably necessary to determine liability for payment of a claim.

(e) The obligation of the insurer to comply with this section shall not be deemed to be waived when the insurer requires its contracting entities to pay claims for covered services.

O